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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/03/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445240	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure dirty areas had an operable exhaust. The findings include: Observation on September 19, 2011 at 11:00 a.m. revealed the restroom exhaust fans on the north wing in patient rooms 201, 211 and 215 did not work upon testing.	K 067	K-067 1) The exhaust fans in rooms 201, 211 and 215 were repaired by our maintenance staff. 2) All exhaust systems were inspected by the Maintenance Director to ensure proper operation. 3) The Maintenance Director will audit all exhaust systems weekly for four weeks then monthly for three months. Then, the audit will take place on the regular preventive schedule. 4) The Maintenance Director will submit the audit results to the Quality Assurance Committee, consisting of the Medical Director, the Director of Nursing, and at least three other staff members, monthly for three months at which point the Quality Assurance Committee will determine the necessity for further monthly review. The administrator will monitor to assure continued compliance has been maintained	10/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 9/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 03 2011